

Cutaneous Leishmaniasis questionnaire

1. District Health Office _____
2. Date of notification to District Health Office ____/____/____
3. Name of reporting physician _____
4. Place of employment of reporting physician _____

Patient personal details

Surname _____ Given name(s) _____ I.D. _____
D.O.B. ____/____/____ Sex [1] Male [2] Female
Nationality: [1] Jew [2] Non-Jew [3] Unknown Health insurance provider _____
Occupation (children – record daytime placement): _____
Current address: City/village/settlement _____
Street _____ House no. _____

Clinical and laboratory information

Date of appearance of first signs of the disease: ____/____/____
Date of definitive diagnosis: ____/____/____

<u>Site of lesion</u>	<u>Nature of lesion</u>	No. lesions ____
Face [1] Yes [2] No	Ulcer [1] Yes [2] No	
Limbs [1] Yes [2] No	Nodule [1] Yes [2] No	
Other [1] Yes [2] No	Other [1] Yes [2] No	
If yes, specify _____	If yes, specify _____	

Was a laboratory diagnosis made? [1] Yes [2] No [3] Do not know

If so, what were the results of the following tests? Please record as follows:

[1] Positive result [2] Negative result [3] Not carried out

Test	Result	Date of test
1. Direct smear	[]	__/__/__
2. Histologic examination	[]	__/__/__
3. Culture	[]	__/__/__
4. Serology	[]	__/__/__
5. <i>Leishmania</i> skin test	[]	__/__/__
6. PCR	[]	__/__/__

Type of *Leishmania* (if identified):

1. *tropica*
2. *major*
3. *infantum*
4. Other _____

1. **Epidemiologic data**

Have you moved house in the 12 months preceding the diagnosis of the illness?

[1] Yes [2] No [3] Don't know

If you have:

Previous address _____

Date of move _____

Sites/areas of presumed infection* (specify precise address and period spent in that place)

Address

Period spent at that place

* e.g., Near home, on military reserve duty, holidays, sleeping out in the open, sitting on porch or in garden

Were you bitten by an insect other than a mosquito? [1] Yes [2] No [3] Don't know

If yes, describe the insect _____

If yes, please fill out the following table:

Place (precise location and description, e.g., garden, lawn, beach etc.)	Season when bitten	How do you know you were bitten?	Time of day when bitten	Were other people in the same place bitten at the same time?
	<input type="checkbox"/> Spring <input type="checkbox"/> Summer <input type="checkbox"/> Fall (Autumn) <input type="checkbox"/> Unknown	<input type="checkbox"/> Pricking feeling <input type="checkbox"/> Itch <input type="checkbox"/> Mark on skin <input type="checkbox"/> Other	<input type="checkbox"/> Evening <input type="checkbox"/> Night <input type="checkbox"/> Morning <input type="checkbox"/> Unknown	<input type="checkbox"/> No <input type="checkbox"/> Only a few <input type="checkbox"/> Most of them <input type="checkbox"/> Unknown
	<input type="checkbox"/> Spring <input type="checkbox"/> Summer <input type="checkbox"/> Fall (Autumn) <input type="checkbox"/> Unknown	<input type="checkbox"/> Pricking feeling <input type="checkbox"/> Itch <input type="checkbox"/> Mark on skin <input type="checkbox"/> Other	<input type="checkbox"/> Evening <input type="checkbox"/> Night <input type="checkbox"/> Morning <input type="checkbox"/> Unknown	<input type="checkbox"/> No <input type="checkbox"/> Only a few <input type="checkbox"/> Most of them <input type="checkbox"/> Unknown

	<input type="checkbox"/> Spring <input type="checkbox"/> Summer <input type="checkbox"/> Fall (Autumn) <input type="checkbox"/> Unknown	<input type="checkbox"/> Pricking feeling <input type="checkbox"/> Itch <input type="checkbox"/> Mark on skin <input type="checkbox"/> Other	<input type="checkbox"/> Evening <input type="checkbox"/> Night <input type="checkbox"/> Morning <input type="checkbox"/> Unknown	<input type="checkbox"/> No <input type="checkbox"/> Only a few <input type="checkbox"/> Most of them <input type="checkbox"/> Unknown
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Do you use personal protective measures against mosquito, sandfly, or other insect bites?

Fans	Insect repellent on skin (in the home)	Insect repellent on skin (outside the home)	Vaporizing tablets or liquid	Repellent candles or coils	Spraying within the house	Spraying outside the house	Other
<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
<input type="checkbox"/> No	<input type="checkbox"/> No	<input type="checkbox"/> No	<input type="checkbox"/> No	<input type="checkbox"/> No	<input type="checkbox"/> No	<input type="checkbox"/> No	<input type="checkbox"/> No
<input type="checkbox"/> Sometimes	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Sometimes

Are there screens on the windows and doors in your home? [1] Yes [2] Partial [3] No

If yes, are they intact and in good condition? [1] Yes [2] No

Does your home have a private garden? [1] Yes [2] No [3] Don't know

Is there a public park near your home? [1] Yes [2] No [3] Don't know

Do you tend to spend time outdoors: in the garden, near your home, in the neighborhood ? [1] Yes [2] No [3] Don't know

During what hours of the day? [1] Morning [2] Afternoon [3] Evening [4] After sunset or at night

Information on other family members, relatives, community members, hiking companions etc. who visited or were together with the infected person in the above places, and developed cutaneous leishmaniasis

Name	Sex	Age	Relationship	Address	Date disease onset

Do you consent to the information obtained from this interview being given to inspectors from the Environmental Protection Department?

Yes/No

If yes, please sign here _____

If the consent was by telephone, please state.

Name of interviewer _____

Position _____